

NOTICE OF INDEPENDENT REVIEW DECISION

Date: January 9, 2003

AMENDED

RE:

MDR Tracking #: M2-03-0376-01

IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an orthopedic surgery physician reviewer who is board certified in orthopedic surgery. The orthopedic surgery physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant was apparently injured on ___ while lifting some boxes. Her first medical consultation was on 10/16/02 with the doctor with complaints of low back pain. She was followed up and continued to have complaints of low back and then developed a lot of neck problems. She subsequently underwent extensive treatment and diagnostic testing for her neck. She underwent surgery for a cervical fusion in 1993. For the next six or seven years she also had continued complaints of neck pain and was treated extensively and had multiple diagnostic tests without much improvement. On 12/23/97 the doctor, treating physician, gave her a 24% impairment rating with a date of maximum medical improvement (MMI) of 12/17/97. The impairment rating was for the cervical spine. There was no mention of any persistent back problems.

In the year 2000, she began to undergo treatments for her lower back. In November 2001 the doctor noted her low back pain had been worse for months, after she had had some increased back pain after standing up after Thanksgiving dinner. Subsequent workup including multiple radiographic tests and discogram demonstrate a spondylolisthesis at L5-S1 and positive discogram at L5-S1; therefore, the doctor recommended proceeding with a laminectomy and discectomy at L5-S1 with a posterior lumbar interbody fusion.

Requested Service(s)

Laminectomy/discectomy at L5-S1 posterior lumbar interbody fusion Transverse Fusion with Fixation.

Decision

The operative procedure is medically necessary.

Rationale/Basis for Decision

The claimant sustained a back injury in _____. In 2001, after standing up after Thanksgiving dinner, she reported increased back pain. Workup identified spondylolisthesis; L5 on S1 and, on discogram, there was concordant pain at L5-S1. The documentation supports the medical necessity of a laminectomy/discectomy at L5-S1 with fusion.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (pre-authorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, and P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t) (2)).

Sincerely,

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requester and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 10th day of January 2002.